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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the release of my x-ray films and/or my medical records, copies, or such and request they be sent ASAP to:

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______ G. Edward Copeland, III, M.D.

______ Alexander J. Haick, Jr., M.D.

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PATIENTS INFORMATION AS LISTED ON ALL RECORDS:

Patient Name: ______________________________

Patient Date of Birth: ______________________ Patient SS#: ______________________

Patient Address: ______________________________

Patient Phone Number: ______________________________

Disclose the following PHI for treatment dates ______________ to ______________ (if no dates entered, send all)

(Please check the applicable item or items)

( ) Entire Chart ( ) Progress Notes ( ) Procedure Op Notes/ Hospital Summary ( ) Lab ( ) X-ray Report

( ) Telephone Message ( ) Pathology Report ( ) Other Specified: ______________________

The above information is disclosed for the following purposes: (Please check all applicable)

( ) Medical Care ( ) Legal ( ) Insurance ( ) Personal ( ) Other: ______________________

I understand that medical records may include information regarding a sexually transmitted disease, AIDS, or HIV infection as well as information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by confidentiality rules. I also understand that the degree of confidentiality can be modified with a facsimile transmission and that the Practice and Physician are not responsible for records once they have been transmitted.

I choose to have my records faxed. ______________ (please initial)